

Client Intake Form – Therapeutic Massage

Name _____ Date _____

Phone (day) _____ Cell _____ DOB _____

Mailing Address _____

City, _____ State _____ Zip _____

Email _____

Emergency Name and Phone _____

Have you had a professional massage before? _____ If so, when was your last massage _____

Relaxation or pain management _____

Do you have an allergic reaction to oils, lotions, or creams? _____

Any other allergies? _____

What is your primary goal for today's massage session? Pain management or Relaxation (circle one)

Are there areas you would like for us to focus on today?

Medical History

Are you currently under medical supervision? If yes, please explain

What medications are you currently taking

Please check any condition below that applies to you

- | | |
|---|--|
| <input type="checkbox"/> contagious skin condition | <input type="checkbox"/> open sores or wounds |
| <input type="checkbox"/> recent accident or injury | <input type="checkbox"/> surgery within the last 6 weeks? What kind? _____ |
| <input type="checkbox"/> Current Fever | <input type="checkbox"/> Heart Condition |
| <input type="checkbox"/> High or Low Blood Pressure | <input type="checkbox"/> Circulatory Disorder |
| <input type="checkbox"/> Varicose veins | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Cold or flu | <input type="checkbox"/> Other |
-

Are you currently pregnant? _____ If yes, how many weeks? _____

Is there anything about your health history that you think or feel your massage therapist should be made aware of in order to provide a safe and effective massage session for you?

I, _____ understand that massage is provided for therapeutic purposes. If I experience any pain or discomfort during any session, I will immediately inform the therapist. I further understand that massage should never be used as a substitute for medical care. My therapist can not diagnose medical conditions or perform spinal adjustment. Because massage should NOT be performed under certain conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep my therapist updated as to any changes in my medical profile and understand that there is no liability on the therapist's part if I fail to do so.

Client Signature and Date

Therapist Signature
